

European women's views on specialist counselling for female survivors of domestic violence and abuse

Sabine Bohne, University of Osnabruck, Germany

Paula Carrilho, Centro de Estudos para a Intervenção Social (CESIS), Portugal

Angela Morgan, University of Wolverhampton, United Kingdom

Alexandra Silva, Centro de Estudos para a Intervenção Social (CESIS), Portugal

Mario Silva, Centro de Estudos para a Intervenção Social (CESIS), Portugal

Abstract

Counselling for female survivors of domestic violence as practiced in five European countries (United Kingdom - UK, Bulgaria, Italy, the Netherlands and Latvia) was qualitatively explored by researchers in the UK, Germany and Portugal over two years. The effectiveness of current practice was analysed using data from 60 face-to-face interviews with clients who had received counselling. Findings revealed that regardless of which counselling model or approach is used, the effectiveness of specialist domestic violence counselling is dependent upon a positive therapeutic alliance built on mutual trust and respect and, crucially, an understanding of the dynamics of domestic violence and abuse provided by highly qualified counsellors who have received domestic violence training. This article concludes by offering recommendations to inform future funding and policy decisions and avenues for future research.

Key words: Domestic Violence; Counselling; Women

Correspondence: Dr Angela Morgan, angela-morgan@wlv.ac.uk

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Introduction - the prevalence of domestic violence and abuse in Europe

Domestic violence and abuse (DVA) is defined as physical, sexual, psychological, or financial abuse and/or violence which takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour (Sanderson, 2008; Home office and AVA, 2013). An association of between 45% and 70% has been found between a father's violence to the mother and violence to the children (Goodall & Lumley, 2007). Almost three-quarters of children on the UK at risk register live in households where DVA occurs (Mullender et al., 2003).

Domestic violence and abuse is a serious yet underreported issue for criminal justice, social policy and public health arenas, affecting one in four women in the United Kingdom, Bulgaria, Italy, and

Germany, two in five women in Portugal, and more than one in four women in the Netherlands (Criminology Research Institute, 2000; Lisboa et al., 2010; Women's Aid, 2010). No prevalence data are available for Latvia.

Domestic violence and abuse can have long and short-term emotional, cognitive, and behavioural consequences for women (Hester et al., 2007; Holt et al., 2008; Bostock et al., 2009). Available evidence indicates that, for women, DVA is the most likely cause of depression, anxiety and panic attacks, anorexia and other eating disorders, hyper-vigilance, sexual dysfunction, complex posttraumatic stress disorder, self-harm, suicidal ideation, and suicide (Humphreys & Thiara, 2002; Hester et al., 2007; Arthur, 2008; Sani, 2008; Department of Health, 2010a, b; Lisboa et al., 2010).

The European Institute for Gender Equality is currently working on establishing EU-wide indicators on the Beijing Platform for Action, including some related to violence against women (from a total of 10 indicators, seven are related to DVA). One such indicator is a 'minimum of one specialist counselling service in every regional city, one per every 50,000 women, and also an outreach support available to women who have limited access to services' (Council of Europe, 2008, p.38).

Linguistic and cultural barriers complicate efforts to quantify and study DVA in Europe (Alhabi et al., 2010; Kemik et al., 2010) causing controversy surrounding its measurement (Tolan et al., 2006).

Available statistics show that in Europe women are much more likely than men to be victims of DVA and experience multiple incidents (CoE, 2006; Women's Aid, 2009a, b; Kemik et al., 2010). The lifetime prevalence for physical violence by current or former partners ranges from 21% to 33% (Martinez et al., 2006). Similarly, at least 25% of all women have experienced physical violence at least once during their adult lives and, for women between the ages of 16 and 44 years, DVA is the major cause of death and invalidity ahead of cancer, road accidents, and war (CoE, 2002). Recent research suggests that self-harm is 5.8 times more likely to be observed among survivors than non-survivors, attempted suicide under the influence of alcohol and drugs seven times more likely, obsessive behaviours 2.3 times more likely, and suicidal thoughts 2.8 times more likely (Lisboa et al., 2010). One third of all suicide attempts in the UK can be attributed to current or past DVA (Women's Aid, 2010). Female survivors of DVA can have feelings of helplessness and guilt which can affect their coping skills and parenting skills, and also experience feelings of insecurity with their children (Sani, 2008). The likelihood of survivors to feel despair, emptiness, guilt, grief, and sadness is comparatively higher than non-survivors, ranging between 6.6 and 4.4 times more likely (Lisboa et al., 2005). Furthermore, DVA is not mitigated by gender, sex, age, race, ethnicity, class, culture, or religion (Bohne, 2010).

Providing emotional support to DVA survivors plays a key role in assisting recovery and moving on (Holt et al., 2008); counselling can be an effective tool for preventing, managing, and avoiding DVA (McNamara et al., 2008; Dimitrova, 2011). Although evidence exists to suggest that counselling

enables survivors to move on with their lives after abuse (Howard et al., 2003; Dienemann et al., 2007; Abrahams, 2010; Morgan, 2012), it is clear that counselling for survivors is highly complex and there is no consistent research data to demonstrate the efficacy of one approach over another; how counselling is conducted is informed by the counsellor's prior learning and personal beliefs (Roddy, 2011a; b). Moreover, many generalist practitioners lack the specialist knowledge, competence, and confidence necessary to counsel survivors of DVA as working with DVA survivors is not generally taught within counselling courses (McLeod, 2007).

Previous research has highlighted that specialist counselling services for survivors of DVA have been extensively underfunded due to negative perceptions of counselling by grant-givers and policy-makers. This research examined the effectiveness of specialist counselling for survivors of DVA from triangulating diverse views, knowledge, and experience of counsellors and psychotherapists, women who receive counselling, and an assessment of funding and provision of these services in selected EU member states. Although the project demonstrated the effectiveness of specialist counselling and the need for such provision, there is scope here only to report the findings from client data.

Study aims

This research aimed to improve knowledge and awareness of counselling and psychological provision for DVA survivors across the EU, to determine the importance of counselling for longer term recovery and wellbeing, and to evaluate key similarities and differences between different models and approaches to such counselling.

Methodology

Given the research aims, the study was driven by qualitative methods which provided in-depth contextual material on how survivors of DVA experienced counselling. An interview schedule was developed by a team of researchers from the UK, Germany and Portugal, and the final draft distributed to project partners in Bulgaria, Latvia, Italy, the Netherlands and the UK, all of whom delivered services in which the data would be collected. A total of 60 face-to-face interviews were conducted in the home language of respondents, later transcribed

and translated. Data were analysed thematically with emphasis on frequency and strength of comments.

Findings

The interviews started by asking about clients' help-seeking behaviour, in which decision triggers, routes into services and expectations were the main issues. The majority of respondents had been referred by statutory services such as criminal justice workers, social workers, school psychologists, Child Protection Services and police.

Some respondents also reached services through knowledge gained via national campaigns to end violence against women, counselling services' promotional material, searching the Internet and through helplines. Family and friends also played a relevant part in prompting the help-seeking behaviour of respondents or supporting them (in particular in Latvia, Bulgaria and the Netherlands). Help-seeking behaviour was triggered primarily due to the experience of chronic DVA over a long period of time that had resulted in despair and hopelessness; at the time of first contact with the counselling service they had reached breaking point.

'Sheer desperation, because I was suicidal literally, and I thought that at that point if I didn't get some help via counselling or something that there would be tragic consequences.' (UK)

For many, escalation of violence or fear of violence escalation also prompted help-seeking.

'I had this understanding that next time he will beat me to death. I realized that I have to start protecting myself, look for help, because otherwise there will not be a happy ending. And then I started to look for help in a determined way. I had that thought for two years.' (Latvia)

Respondents seemed to be acutely aware that aside from feeling depressed, they were also discontent with their personal circumstances. That said, they were encouraged by how they felt and decided themselves to get help. Nevertheless, children were also identified as triggers to help-seeking behaviour.

'He harasses my daughter at school. He has rented an office right in front of the school and every school break he visits the kid and talks to her, even wants to pick her up after school... and actually, if it was not for the kid, I still would have done nothing.' (Bulgaria)

For Italian respondents - who were considerably older than others with an average age of 53 years -

there was an acknowledgement of the historical and social acceptance of abuse within marriage, but a sudden realisation that what they were suffering was no longer acceptable.

'I was a survivor of sexual violence by who I thought to be my lover (...) after all the repeated signals that I didn't perceive at first because he had beaten me so many times (...). I thought it was the jealousy of a lover.' (Italy)

When survivors reached support services they had limited expectations. The vast majority of respondents in all partner countries had no prior expectations of counselling; furthermore, they had no time to think about what to expect - they only knew they needed help.

'I did not know what to expect. I did not have any such experience. I was hoping for a miracle, that the psychotherapist will do something that makes me feel better. There was no one who could support me.' (Latvia)

However, if respondents did not have any expectations from the service besides overall help, there were things they hoped to gain from their experiences. They wanted to understand more about themselves so they could appreciate how they came to arrive at their current situation, to find out how to get out of it, and sometimes how to end the violence. Importantly, some respondents stated they needed to regain control, and to be in a safe and secure environment with someone who was interested in listening to them.

'I needed someone to listen and hear me and I expected an advice on what should we do. It is very delicate matter; we do not want to undertake actions which might lead to his arrest or other prosecutor's actions. Maybe I expected help in sending him to a rehabilitation facility.' (Bulgaria)

Few respondents knew anything about the counselling model or approach used within their therapy. However, respondents in the United Kingdom, Italy, and Latvia were able to describe some of the key elements that made up their counselling sessions, for example, working with emotions, and skills to reduce harmful behaviours.

'No, frankly, this I don't know. I noticed that it is a kind of approach which is target to listen to the emotions, the feelings of the person, and it is also a way of support.' (Italy)

General perceptions of the counselling process were favourable and positive across all countries. Two

key themes emerged concerning main gains: empowerment and emotional strength with improved feelings of self-worth; and improved knowledge and awareness of DVA and the effect it can have on women.

‘After the counselling session, at the end, I was a totally different person who could face the world without fear.’ (The Netherlands)

Of importance for respondents was the feeling of trust, belief and respect within the relationship with their counsellor which appeared to be integral to the process and meaningful for all respondents.

‘When I feel bad, (...) that I do not know how to cope with it, I can call or visit her. And that calms me, and things get solved somehow, and things change. I want to deal with it by myself, but they give me the security feeling. (...) These relations were very important – trust, belief that this person will understand. (...) For me it is very important to be able to trust and believe, and I received it here.’ (Latvia)

Alongside the process of counselling, respondents were encouraged to be independent in decision-making, and counsellors were non-judgemental, which led to feelings of empowerment. Nevertheless, some help and direction was provided by counsellors in some countries which appeared to undermine client autonomy.

‘In so long a period it’s clear that there has been some change, but there has been because I was changing myself, so about some decisions which I thought were right, at the beginning (...) didn’t agree, she made me understand, in a very calm, clear and polite way; from the beginning there has always been this kind of listening, I noticed there was attention but also she didn’t agree with my choices; now the relation has changed.’ (Italy)

Most outcomes of the counselling process were perceived positively for decision-making, emotional gain, autonomy, problem solving, viewing the future and understanding domestic violence.

In terms of positive outcomes of therapy, respondents experienced many progressive and constructive changes: increased self-esteem and self-worth; confidence and empowerment; improvement in children’s attitudes and behaviour; augmented family bonding; reduced stress and feelings of shame; gaining ability to detach themselves from the violent relationship or otherwise deal with aggression; improved positive outlook; feeling

happy and optimistic; seeing and planning a future, and wanting to live; reduced feelings of hopelessness, helplessness and of being alone; increased and generalised problem-solving skills and communication; greater security and freedom; and understanding the dynamics of domestic violence and abuse.

The therapeutic relationship built between client and counsellor was perceived as a means of suicide prevention for respondents in the UK, and enabling clients to sever the bonds with their abuser in Latvia. The key element to successful positive and effective therapeutic relationships was that they develop gradually. But it was also found across all countries that respondents perceived their involvement in defining therapeutic goals as highly important in ensuring success.

Conclusion and recommendations

The comparative analysis revealed many similarities of specialist counselling between EU countries. The most unequivocal finding was that specialist counselling for women who have been affected by DVA can save lives. Moreover, the listening skills of counsellors contributed to good therapeutic relationships, specialist counselling can result in suicide prevention, and survivors are enabled to sever the bonds with their abuser. The key element to successful positive and effective therapeutic relationships was that they develop gradually. There was no evidence of any theoretical model or approach being more superior for survivors. Rather, the key ingredient of therapeutic success was found to be that counselling *when complemented with specialist training in the dynamics of DVA* achieved better outcomes for survivors. Counselling is also effective when survivors are relatively low risk and when they freely choose to engage with therapy.

Many domestic violence victims do not realise they are being abused therefore do not access appropriate support. However, for those who do recognise abuse and thereafter disclose, swift referral processes are important to enable survivors to be directed to specialist support.

Specialist counselling services across Europe should improve publicity of their facilities and benefits to clients to increase public awareness of the impact of DVA on women and children, and to increase awareness among professionals in other sectors such as education and health. More awareness should enable early recognition of signs of DVA and

increase referrals. Consideration should be given to clients' personal characteristics and domestic context to enable those more at risk of violence escalation to be offered alternative interventions. For generic counsellors to become specialist counsellors, it is essential they have access to specialist and dedicated training courses to learn the dynamics of DVA.

All member states should observe Article 20 of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, particularly in taking the necessary legislative measures to ensure survivors have access to services facilitating their recovery. There should be a minimum of one specialist counselling service in every regional city, one per every 50,000 women and also an outreach support available to women who have limited access to services. Currently, only eight member states meet the recommendation.

Women's centres and services are essential support measures for women. They provide both immediate information and safety support and, for the longer term, counselling and other support to aid their recovery. Survivors should have access to health care and social services which are adequately resourced, and professionals should be trained to assist survivors and refer them to appropriate services.

Further research

Due to the varying sociologic, economic, and political contexts, domestic violence and abuse is defined and quantified in dissimilar ways across the EU, thus the problem of comparability and usefulness of data become issues (CAHRV, 2006). This indicates the need for universally agreed measurement criteria, the benefit of which would be provision of reliable data and up-to-date information needed by key stakeholders and policy-makers to inform policies aimed at tackling DVA in the EU; this is a key objective of the European Union Agency for Fundamental Rights survey on Violence against Women (EUAFR, 2011).

There are a number of ways in which future research may contribute to the area of specialist counselling for women survivors of DVA. Research is needed to explore and improve pathways of care for children experiencing DVA - this is an under-researched area. Respondents in Italy and Bulgaria presented within an older age range than other participant countries, with some women stating that they could

see no future and subsequently held no hope for themselves, showing clearly that the negative impact of DVA does not only affect young adults and children. Therefore, to further build on the research reported here, more work is required to further understand the experiences and perceptions of older women who are survivors of domestic violence and abuse. We have already noted that specialist counselling can save lives - the lives of older adults are no less important.

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